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#### 45 Lung nodule management in Covid-19: does postponed surveillance matter?

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**Background:** The surveillance scan intervals for lung nodules are well-established. During the first wave of the Covid-19 pandemic, service disruption resulted in delayed 'routine' imaging, associated with a risk of delay in identifying early lung cancers.

**Aim:** To compare final outcomes, including non-attendance, of patients who had surveillance scans postponed during the first wave of COVID-19 pandemic in London with a pre-pandemic cohort.

**Methods:** We identified patients at a teaching hospital with delayed surveillance CT scans (due March-May 2020). Outcomes included upgrade to cancer pathway on scan completion, confirmed cancer diagnosis, and number of patients who declined subsequent surveillance. This patient group was compared with an unmatched cohort from March-May 2019.

**Results:** 91 patients (median scan delay 5 months) were identified versus 63 patients in 2019 (median age 72,53% female in 2020; median age 69,57% female in 2019). 66% of patients in the 2020 cohort were smokers, and the median Charlson Comorbidity score was 4 (IQR 3–6). 57% of patients in the 2020 cohort missed 3-month scans, and 31.5% missed a 12-month scan. In the 2020 cohort, 16 patients (18%) did not continue with surveillance: 6 patients died prior to next scan, and 10 patients declined further CTs due to Covid-19 concerns. 14 patients were upgraded and 4 had a biopsy-proven lung cancer diagnosis, all Stage 1. 10 patients remain under radiological surveillance specifically due to ongoing Covid-19 risk. 37 patients were discharged, with 24 patients under ongoing nodule surveillance. In 2019, 28 patients were upgraded, with 7 proven cancers, and just 9 discharged.

**Discussion:** In this cohort, longer time intervals supported confident early discharge, with no concurrent excess of upstaged cancers. Importantly given the co-morbidity and risk profile, in the context of Covid-19, patient choice and morbidity impacted patients proceeding with investigations even once services resumed.

**Disclosure:** No significant relationships.

#### 46 Evaluation of telephone consultations for follow up lung cancer patients at Royal Papworth Hospital, undertaken instead of face-to-face consultations during the Covid-19 pandemic

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**Introduction:** During March 2020, routine clinic follow-up of lung cancer patients at Royal Papworth Hospital was reconfigured due to the Covid-19 pandemic. New lung/thoracic cancer diagnoses were seen face-to-face, but all routine follow-ups became telephone consultations (TCs), minimising virus exposure/spread. TCs were conducted by chest physicians, oncologists, surgeons and nurses. Any patient identified with clinical need was seen face-to-face.

**Methods:** A questionnaire, including pre-paid return envelope, was posted to patients who had a TC from mid-March to end-May 2020. Project supported by Royal Papworth Charity Covid-19 fund and Audit Department.

**Results:** 411 questionnaires sent, 214(52%) responses received; from 40 TCs in March, 87 in April and 87 in May. 212(99%) had the TC at

a convenient time, 185(86%) by their familiar doctor or nurse. 184 (86%) patients faced no challenges, 28 (13%) reported challenges including hard of hearing, anxiety of not having chest X-ray, history not fully known and preference for face-to-face. 153 (71%) patients did not have anyone listen in; 86 by choice, 49 not by choice but due to living alone, no one available or self-isolating. 88% were satisfied their needs had been met, finding the TC helpful and friendly. 90% felt listened too, able to ask questions and aware of follow-up plans. 182 (85%) happy to receive TC again if appropriate, feeling safer not attending hospital. 26 (12%) wanted to be seen face-to-face. Mixed comments were received. For some attending hospital was stressful, saving on parking and travel was good. Approximately 60/40 split of patients who did not have access to or wish to consider using video technology, to those who would give it a try or already using.

**Conclusions:** Results demonstrate positive experience of TCs for follow-ups during the Covid-19 pandemic. Need for a chest X-ray or CT scan featured understandably as reason to be seen face-face.

**Disclosure:** No significant relationships.

#### 47 The impact of COVID-19 on lung cancer diagnostics – a multicentre comparison of 2019/2020 data

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**Introduction:** The importance of timely diagnostic procedures for lung cancer patients is well established. We aimed to examine the impact of the pandemic on imaging and tissue acquisition techniques for lung cancer.

**Methods:** Data on CXRs, PET-CT scans, CT guided biopsies and EBUS procedures were collected retrospectively from 5 Trusts/ Cancer Alliances in England and Wales for the period January to September 2019 and 2020. The participating sites were Nottingham University Hospitals NHS Trust, Royal Papworth Hospital NHS Foundation Trust, University College London Hospitals NHS Foundation Trust, Greater Manchester Cancer Alliance and Cwm Taf Morgannwg University Health Board.

**Results:** The total number of CXRs for suspected lung cancer carried out at the contributing sites in 2020 was 113677, compared to 182154 in 2019. The number of CXRs fell to a nadir in April 2020, when 24% of CXRs were performed compared to April 2019. The number of PET-CT scans and CT guided biopsies both fell by 50% in May 2020, compared to May 2019. EBUS procedures also dropped by 54% in April 2020 compared to April 2019 and by 50% compared to the month before (Fig. 1). CT biopsies recovered more effectively than EBUS cases. Up to September 2020, CT biopsies were 85% of those carried out in 2019, while the number of EBUS cases in 2020 were 69% of 2019. By Sept 2020, the numbers of CXRs, CT guided biopsies and EBUS procedures had not recovered to pre-pandemic levels.

**Conclusion:** COVID-19 has severely impacted the diagnostic pathway for lung cancer patients. In addition to re-establishing early diagnosis initiatives, action is required by key stakeholders (ie, individual NHS trusts, Cancer Alliances, Clinical Commissioning Groups and NHS England) to ensure adequate capacity exists for rapid diagnostic pathways.

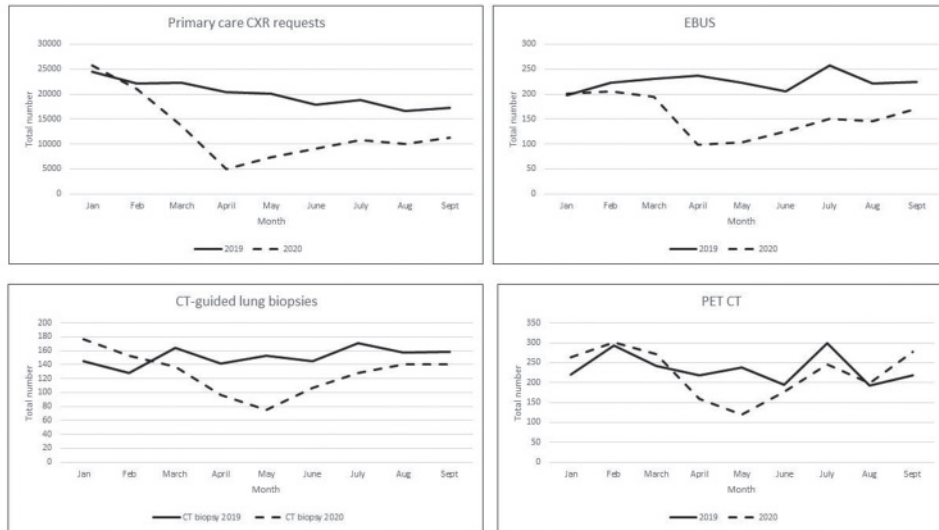


Fig. 1 (abstract 47). Lung cancer diagnostic tests.

**Disclosure:** No significant relationships.

#### 48 Increased emergency presentation of new lung cancer diagnoses and less treatment: a COVID legacy

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**Introduction:** In the United Kingdom, thirty-nine per cent of patients with lung cancer are diagnosed after an emergency presentation (EP) to acute medical services. This is associated with a worse prognosis and reflects diagnostic delay. The COVID-19 pandemic has affected cancer diagnostic services. We investigated the rates of EP of lung cancer, disease stage and treatment rates in the aftermath of COVID-19.

**Methods:** A retrospective analysis of thoracic malignancies diagnosed at Chelsea and Westminster Hospital for 12 months before and after the COVID-19 pandemic. 1st March 2020 was chosen as the start date of the pandemic. EP was defined as an attendance at an acute medical facility in the 2 months prior to diagnosis.

**Results:** 186 patients were diagnosed with a thoracic malignancy in the 12 months before, and 237 patients in the 12 months after, COVID-19. 85 (46%) and 149 (63%) respectively were diagnosed as part of an EP ( $\chi^2 = 12.43$ ;  $p=0.0004$ ). Before COVID-19, 98 of 178 patients (55%) with non-small cell or small cell lung cancer had advanced (stage 3B/C or 4A/B) disease, increasing to 143 of 224 patients (63.8%) after the pandemic started ( $\chi^2 = 3.18$ ;  $p=0.07$ ). Of 98 patients with advanced stage disease, 52 (53.1%) received systemic anti-cancer therapy (SACT) prior to COVID-19, falling to 49 of 143 (34.3%) patients after ( $\chi^2 = 8.87$ ,  $p=0.002$ ).

**Conclusions:** There was a statistically significant increase in EP of thoracic cancers during the pandemic, and an increase in the proportion of patients diagnosed with advanced stage disease. This likely reflects patient difficulty and fear accessing primary and elective secondary care diagnostic services. Fewer advanced stage patients received SACT. The increase in EP and decrease in treatment is expected to foretell an increase in lung cancer related mortality, another COVID-19 legacy.

**Disclosure:** No significant relationships.

## Diagnosis and Staging

#### 49 Establishment of an ambulatory thoracoscopy service

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**Introduction:** The COVID-19 pandemic meant that patients with advanced cancer are at risk of nosocomial acquisition of COVID-19 during hospital stays. To reduce the risk to our patients, we established an ambulatory thoracoscopy service in June 2020. Previously, patients who underwent pleurodesis during thoracoscopy were admitted. Instead, we now insert an indwelling pleural catheter following pleurodesis.

**Methods:** Retrospective case notes review of patients attending for diagnostic semi-rigid thoracoscopy at the Norfolk and Norwich Pleural Unit since June 2021. All cases and biopsy results were discussed in the lung cancer MDT and a final diagnosis made.

**Results:** Twenty patients considered appropriate for ambulatory thoracoscopy have undergone thoracoscopy since June 2020 (15 male:5 female). Mean age was 70 years. Of these, 19/20 were successfully managed as day cases, 9/20 had IPC insertion during the procedure and 3/20 had talc pleurodesis. One patient developed significant pain following pleurodesis and IPC insertion was not possible and he was admitted for 2 days. Another patient also experienced pain, but there were no other complications. There were no readmissions due to complications following thoracoscopy. Nineteen yielded a diagnosis which matched the final MDT diagnosis, giving an overall sensitivity of 95%.

**Conclusions:** Ambulatory thoracoscopy is safe and achievable in most patients with high diagnostic yields.

**Disclosure:** No significant relationships.

#### 50 Case series of ctDNA EGFR testing for non-smoking lung cancer

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**Introduction:** The main clinical use of ctDNA EGFR testing has been for the detection of secondary EGFR mutations. We present our experience of upfront testing for poor performance status, non-smoking patients.